Division of Human Resources

HealthLine

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Changes for **Medical Options**

As you complete your open enrollment this year, you will notice the names of the State's medical insurance options have changed for the FY 2011–12 plan year.

THE OPTIONS ARE THE SAME ONES YOU KNOW—only their names in the Benefits Administration System (BAS) have changed. There are two PPO options, which are administered by UnitedHealthcare and use their network of providers. There are two HMO options, offered in two locations, which are offered by Kaiser Permanente and use their network of facilities and providers.

Medical Insurance Options—New Names in the BAS for FY 2011–12

Old Name	New Name in BAS for FY 2011–12
UHC Choice Plus Co-Pay	PPO Co-Pay Choice+ FY12 (UnitedHealthcare Network)
UHC Choice Plus Definity HDHP	PPO HDHP Definity FY12 (UnitedHealthcare Network)
Kaiser DenBou HMO	HMO Co-Pay DenBou FY12 (Kaiser Permanente)
Kaiser SoCo HMO	HMO Co-Pay SoCo FY12 (Kaiser Permanente)
Kaiser DenBou HDHP	HMO HDHP DenBou FY12 (Kaiser Permanente)
Kaiser SoCo HDHP	HMO HDHP SoCo FY12 (Kaiser Permanente)

Special Note to CU State Classified Staff

State personnel system employees with the University of Colorado **MUST** use CU's online system for open enrollment.

FY 2011–12 **Open Enrollment**—Logistics and Facts

Information & Resources at Employee Benefits Web Site

- Open enrollment is **Wednesday, April 20–Monday, May 23, 2011.** Participation is **MANDATORY**, as current medical and dental coverage **WILL NOT** roll forward into the next plan year. If you do not make a choice for medical and dental coverage during open enrollment, you and your family will not have medical and dental coverage for the FY 2011–12 plan year, which starts July 1, 2011.

Requiring employees to make new medical and dental elections every year allows employees to become more familiar with available options, leading to a better understanding of their final choices. Even in year like this, when there are few changes, the premiums are different, the influences on employees' choices, like personal health and finances, have changed. It also affords employees the opportunity to update information on themselves and their family.

- Enrollment is for the FY 2011–12 Plan Year—July 1, 2011 to June 30, 2012.
- Open enrollment is completed ONLY through the State's online Benefits Administration System (BAS), accessed at the Employee Benefits Web site, where you can also research your benefit options, view premiums, review online system instructions.
- Flexible Spending Accounts (FSAs) do not roll over to the next plan year, and must be chosen every year. **Those who want an FSA in FY 2011–12 must enroll in the FSA during open enrollment.**
- *Open enrollment is the ONLY TIME to make changes to your benefits, except in very limited, life altering circumstances. Forgetting to enroll, not confirming online choices, suffering a financial hardship, or just a change of mind are not permitted reasons for making changes beyond open enrollment (per IRS regulations).*
- Social security numbers for spouses, same-gender domestic partners and dependent children are required when enrolling.
- Complete your enrollment early to avoid last-minute problems.
- Use open enrollment to update dependent information and remove any ineligible dependents (e.g., overage children, ex-spouses).
- Be sure to go all the way through your open enrollment election. On the confirmation page you must click "I Agree" for your choices to be submitted. You are finished when you get to the screen that says, "Enrollment Complete."
- If you are terminating your employment with the State *before* July 1, 2011, YOU SHOULD PARTICIPATE in the FY 2011–12 open enrollment. Contact the State's COBRA administrator at 1.877.725.4545 for information about COBRA continuation coverage.

Two Big Changes for FY 2011–12

For the upcoming FY 2011–12 plan year, there will be two changes to the benefit plans, both the result of healthcare reform, that will stand out for most employees.

Preventive Services

For all of the State's medical insurance options, recommended preventive services, as defined by and in compliance with the Affordable Care Act, also known as federal healthcare reform, will be covered at no charge to the member—no co-pay, no deductible, no co-insurance—so long as services are provided by in-network providers and follow the frequency guidelines.

So what are considered preventive services under healthcare reform? It's a list too long for here, but it includes annual physicals, age-appropriate screenings, and age-appropriate immunizations.

Find lists of covered preventive services for the State medical options at the Web pages for each option. Look for "Preventive Care."

- ✗ PPO Co-Pay Choice Plus
- ✗ PPO HDHP Definity
- ✗ HMO Co-Pay
- ✗ HMO HDHP

More information and specifics are available at the following sites.

www.healthcare.gov/law/about/provisions/services/lists.html
- A complete list of recommendations and guidelines to be covered under federal healthcare reform regulations.

www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- List of evidence-based preventive services with an "A" or "B" rating from the U.S. Preventive Services Task Force. Healthcare reform stipulates coverage of A and B-rated services.

www.cdc.gov/vaccines/recs/schedules/default.htm
- Immunizations appearing on the Immunizations Schedules of the Centers for Disease Control and Prevention and recommended for routine use by the Advisory Committee on Immunization Practices.

Coverage for 25-Year-Olds

For the FY 2011–12 plan year, employees will be able to cover dependent children up to their 26th birthday for medical, dental, and dependent child life insurance. This means that during this open enrollment, employees can add, or maintain, coverage for their 25-year-old dependent children. In addition, healthcare expenses for most of these dependents can be reimbursed from an employee's *healthcare* flexible spending account (FSA). Dependent coverage ends on the month in which a child turns 26. Expenses for same-gender domestic partners (SGDP) and their children *cannot* be reimbursed from an FSA.

Terminating Coverage Outside of Open Enrollment—Be Careful

While this will be welcome news for many people, employees must be cautious when enrolling their adult-aged dependents (19–25) as healthcare reform also changed the factors for a dependent child's eligibility for medical or dental coverage. Age and relationship to the employee will now be the only factors. Residence in the employee's home, financial support from the employee, the child's student status, and the child's marital status no longer impact his or her eligibility for medical or dental coverage under the parent's plan.

Employees have always been able to drop a dependent in the middle of the plan year due to a change in eligibility. However, as eligibility will no longer require that a child be unmarried, living in the employee's household, financially dependent upon the employee, or even claimed as a dependent on the employee's tax return, there will be very few circumstances under which an employee will be able to remove a child from coverage in the middle of the year.

An employee can cover a child aged 19–25 for medical, dental, and child life insurance in the next plan year, but if the child moves out of the employee's house, stops receiving financial support from the employee, graduates from college, or gets married, an employee ***cannot*** terminate the child's medical and dental coverage with the State outside of open enrollment, as the child's eligibility has not been impacted.

Enrolling Outside of Open Enrollment

Employees should also be aware that if an employee chooses to **not enroll** a 19–25-year-old child during open enrollment, the employee will not be able to enroll the child later, after the plan year begins on July 1, even if he or she moves back home, becomes financially dependent upon the employee, or gets divorced. There is one exception. If an employee chooses to not cover a 19–25-year-old because he or she is covered under his or her own employer's plan, but the child later loses that coverage when he or she leaves the job, the employee may enroll the child within 31 days of the conclusion of that coverage. Documentation of the loss of that coverage will be required to make such a change.

For detailed, consumer-oriented information regarding all aspects of federal healthcare reform, visit www.healthcare.gov.

FY 2011–12 Medical and Dental Premiums

FY 2011–12 MEDICAL OPTIONS				
OPTION	**TIER**	**Total Premium**	**State Contribution**	**Employee Contribution**
PPO HDHP Definity FY12 (UnitedHealthcare) HSA-qualified option	Employee Only	$403.16	$368.42	$34.74
	Employee + Spouse	$877.74	$623.42	$254.32
	Employee + Child(ren)	$721.76	$659.66	$62.10
	Ee + Sp + Child(ren)	$1,199.66	$914.50	$285.16
PPO Co-Pay Choice Plus FY12 (UnitedHealthcare)	Employee Only	$444.46	$368.42	$76.04
	Employee + Spouse	$992.16	$623.42	$368.74
	Employee + Child(ren)	$841.88	$659.66	$182.22
	Ee + Sp + Child(ren)	$1,380.12	$914.50	$465.62
HMO HDHP FY12 HSA-qualified option (Kaiser Permanente)	Employee Only	$410.90	$368.42	$42.48
	Employee + Spouse	$895.46	$623.42	$272.04
	Employee + Child(ren)	$733.60	$659.66	$73.94
	Ee + Sp + Child(ren)	$1,218.08	$914.50	$303.58
HMO Co-Pay FY12 (Kaiser Permanente)	Employee Only	$461.24	$368.42	$92.82
	Employee + Spouse	$1,058.26	$623.42	$434.84
	Employee + Child(ren)	$878.96	$659.66	$219.30
	Ee + Sp + Child(ren)	$1,416.14	$914.50	$501.64

FY 2011–12 DENTAL OPTIONS				
OPTION	**TIER**	**Total Premium**	**State Contribution**	**Employee Contribution**
Dental Basic	Employee Only	$25.74	$23.80	$1.94
	Employee + Spouse	$47.02	$39.00	$8.02
	Employee + Child(ren)	$47.02	$41.18	$5.84
	Ee + Sp + Child(ren)	$68.30	$56.38	$11.92
Dental Basic Plus	Employee Only	$37.18	$23.80	$13.38
	Employee + Spouse	$68.78	$39.00	$29.78
	Employee + Child(ren)	$68.78	$41.18	$27.60
	Ee + Sp + Child(ren)	$100.36	$56.38	$43.98

This premium information reflects the State funding level as currently reflected in the Long Bill, which is in the final stages of the legislative process. Should these employer contribution amounts change, the State and employee contributions will be adjusted accordingly amongst the four coverage levels. If adjusted contributions become necessary, a revised chart will be made available on the Employee Benefits Web site www.colorado.gov/dpa/dhr/benefit and sent to your department's benefits, payroll, and HR staff. Watch for communication from Employee Benefits or from your department for any updates. However, do not delay your open enrollment until the last minute.

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Medical Insurance

Employees must make new choices for state medical insurance during open enrollment, as current choices will not roll forward into the FY 2011–12 plan year (starting July 1, 2011).

PPO Co-Pay Choice Plus FY12/PPO HDHP Definity FY12 *(both use the UnitedHealthcare Network)*
www.welcometouhc.com/colorado (a pre-member site)
www.myuhc.com (member site, requires username and password)
1.877.283.5424

	PPO Co-Pay Choice Plus (UnitedHealthcare Network)	PPO HDHP Definity® (UnitedHealthcare Network)
Benefit	Network/Non-network	Network/Non-network
Deductible		
Employee	$1500/$3000	$1500/$4500
Family***	$3000/$6000	$3000/$9000
Out-of-pocket maximum		
Employee	$5000/$10,000	$3000/$9000
Family***	$10,000/$20,000	$6000/$18,000
Lifetime maximum benefit	Unlimited	Unlimited
Annual adult physical	100%/50%	100%/50%
Well-child visits	100%/50%	100%/50%
Mammogram	100%/50%	100%/50%
PSA tests	100%/50%	100%/50%
Doctor visit	100% after $30 co-pay/50%*	80% after deductible has been met/50%*
Specialist visit	100% after $50 co-pay/50%*	80% after deductible has been met/50%*
Urgent care visit	80% after $75 copayment per visit Deductible does not apply/50%*	80%*/50%*
Emergency room	80%*	80%*
Ambulance	80%*	80%*
Outpatient surgery	80%*/50%*	80%*/50%*
Lab and X-ray	Preventive: 100%/50% Diagnostic: 80%*/50%*	Preventive: 100%/50% Diagnostic: 80%*/50%*
Hospital stay	80% after $1000 copayment per inpatient stay/50%*	80%*/50%*
Mental health services	Outpatient at 100% after a $30 copayment per visit/50%*	80%*/50%*
Pharmacy	Retail (up to a 31-day supply) Tier 1 $10 Tier 2 $25 Tier 3 $50 Mail Order ** (up to a 90-day supply) Tier 1 $25 Tier 2 $62.50 Tier 3 $125	Retail (up to a 31-day supply) Tier 1 $10 Tier 2 $25 Tier 3 $50 Mail Order ** (up to a 90-day supply) Tier 1 $25 Tier 2 $62.50 Tier 3 $125 Co-pays apply after you've reached your deductible

* After you've reached your deductible

** Only certain prescription drugs are available through mail-order; visit www.welcometouhc.com/colorado for more information.

*** Employee plus spouse/same-gender domestic partner/child or children/family

This information is a brief, general description of coverage and is not a contract and does not replace the Summary of Benefits.

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Connected Care

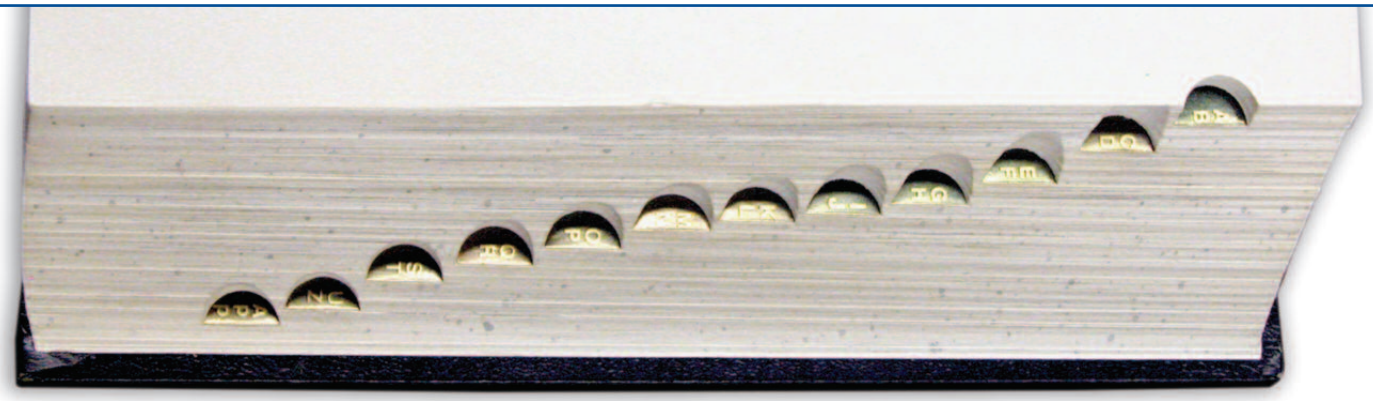
Connected Care is a new, convenient way for State employees living in southeast or south central Colorado to get specialized medical care, where access to a specialist isn't always easy. Connected Care uses sophisticated high-definition technology to deliver an experience remarkably similar to in-person visit with a doctor.

This is available to employees choosing either PPO option using the UnitedHealthcare network (*Co-Pay Choice Plus* or *HDHP Definity*). With Connected Care, members will have access to a variety of UnitedHealthcare specialists affiliated with Centura Health. It can be used for initial diagnoses as well as follow-up visits.

Appointments are scheduled through the Connected Care system. Like any appointments, members are responsible for regular co-pays, co-insurance, or deductibles. However, there are no additional charges for accessing this program.

Locations currently providing Connected Care.

- **Del Norte Hospital**
  Scheduling: 719.657.2418
- **Buena Vista Family Practice**
  Scheduling: 719.395.9048
- **High Plains Community Health Center, Lamar**
  Scheduling: 719.336.0261



Healthcare Terminology—Knowing these terms will help you to understand your choices.

Co-Pay—A flat fee that is paid for health care services at the time service is provided. Co-payments are specific amounts, which is convenient in planning for the cost of care.

Deductible—An amount an individual must pay for covered health care expenses before insurance begins to cover costs. Deductibles in health insurance work the same as deductibles in auto or home owner's insurance.

Co-insurance—A percentage of costs for covered services that the insurance company pays *after* a deductible is met.

Out-of-Pocket Maximum—The maximum amount of money a person will pay for covered health claims, which is in addition to premium payments. These maximums are usually the sum of deductibles and co-insurance payments or the sum of all co-payments.

HMO Co-Pay FY12/HMO HDHP FY12 *(both use Kaiser Permanente network)*
Available in Denver, Boulder, and parts of Southern Colorado
www.kp.org
303.338.3800—Denver–Boulder area
1.888.681.7878—Southern Colorado

Benefit	HMO Co-Pay (Kaiser Permanente)	HMO HDHP (Kaiser Permanente)
Annual Deductible		
Individual	No deductible	$1200
*Family**	No deductible	$2400
Out-of-Pocket Max (OPM)		
Individual	$1000	$2500
*Family**	$3000	$5000
Lifetime Max	unlimited	unlimited
Office Visit Copayment		All benefits subject to deductible and all coinsurance applies to OPM
Primary Care	$30 co-pay	10% coinsurance
Specialty Care	$50 co-pay	10% coinsurance
Preventive Care	No charge (100% covered)	No charge (100% covered)
Prescription Drugs		
Generic	$10 co-pay	$10 co-pay (after deductible, applies to OPM)
Brand	$30 co-pay	$40 co-pay(after deductible, applies to OPM)
Self-injectibles	20% coinsurance up to $75 max per script	20% coinsurance up to a $100 max per script
Mail order	Up to a 90-day supply available for 2 co-pays	Up to a 90-day supply available for 2 co-pays
Inpatient Hospital	$750 co-pay	10% coinsurance
Outpatient/Ambulatory Care	$150 co-pay	10% coinsurance
Diagnostics		
Diagnostic Lab and X-ray	100% covered	10% coinsurance
Therapeutic X-ray	$50 co-pay	10% coinsurance
MRI/CAT/PET	$100 co-pay per procedure	10% coinsurance
Emergency Care	$100 co-pay	10% coinsurance
Ambulance	20% coinsurance to a max of $500 per trip	10% coinsurance
After-Hours Care	$50 co-pay	10% coinsurance
Mental Health		
Inpatient Hospital	$750 co-pay	10% coinsurance
Outpatient Care	$30 co-pay	10% coinsurance

* Employee plus spouse/same-gender domestic partner/child or children/family

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HDHPs & HSAs

HDHPs, or high-deductible health plans, are medical insurance plans that typically have lower premiums, and higher deductibles, than other types of medical insurance. Members are expected to pay for healthcare costs until the deductible is met, which is when the insurance kicks in. However preventive care is covered *without* meeting the deductible. HDHPs strive to make members better healthcare consumers, enabling them to more closely scrutinize healthcare decisions.

HDHPs are designed to be used with Health Savings Accounts (HSAs), although it is not a requirement. An HSA is a special kind of saving account, similar to an IRA, for saving for future medical expenses. You cannot establish or contribute to an HSA without being enrolled in an HDHP (sometimes called an HSA-qualified plan). For an HDHP to be HSA-qualified, it must meet certain federal regulations.

For FY 2011–12, the State will again offer two HDHP options: 1) PPO HDHP Definity (UnitedHealthcare network); and 2) HMO HDHP (Kaiser Permanente network; only available in certain geographic areas served by Kaiser). Those who want an HSA are free to open an account at a financial institution of their choice, such as banks and credit unions. In choosing an institution, employees should ask about set-up and maintenance fees, as well the methods for using an HSA—checks or debit cards.

Important Factors When Considering an HSA-qualified option

✔ All covered services, except for certain preventive services, are subject to the medical deductible.

✔ Prescriptions and HDHP options

- Unlike the other medical insurance options, **within an HDHP, the entire deductible amount must be met before prescription co-payment amounts will apply.** This feature is due to federal regulations for an HDHP to be HSA-qualified.

✔ Individual vs. Family Deductibles

- ***Unlike the other options, an HDHP option has an "umbrella" deductible. This means that if you have family coverage, you must meet the full family deductible before the insurance kicks in.***
- The individual deductible and maximum out-of-pocket amounts ONLY apply to the employee-only tier of coverage. For all other levels of coverage (employee + any dependents—spouse, SGDP, and/or any number of children) there are no individual amounts, only the family amounts of deductibles and out-of-pocket maximums.

✔ Those who want an HSA can set up an account at any institution they choose.

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Dental Insurance—Administered by Delta Dental

Employees **MUST** make a new choice for state dental insurance during open enrollment, as current choices will not roll forward into the FY 2011–12 plan year (starting July 1, 2011).

***IMPORTANT NOTE:* Coverage in both the Basic and Basic Plus plans is based upon the PPO in-network prices for services. PPO in-network dentists have agreed with Delta Dental to not charge above certain amounts for services. Employees and their families are free to use out-of-network dentists, but the coverage is based on the PPO in-network pricing, and the employee will be responsible for the difference between the PPO in-network pricing and the charges for the out-of-network dentist.**

Delta Dental—1.800.489.7168/
www.deltadental.com

Basic Plan

- Plan Year Deductibles—individual $50, Family $150
- Annual Maximum Benefit for an individual—$1000
- Preventive and Diagnostic Services, e.g., routine cleanings, oral evaluations, fluoride treatments, full-mouth and bitewing x-rays, sealants
  - No deductible
  - Paid at 100% of PPO in-network pricing
- Basic Services, e.g., composite (white) fillings, amalgam (silver) fillings, extractions, surgical periodontal (gums), root canal therapy
  - Deductible must be met before services paid
  - Paid at 70% of PPO in-network pricing
- Major Services, e.g., crowns, full and partial dentures, bridges, implants
  - Deductible must be met before services paid
  - Paid at 50% of PPO in-network pricing
- No orthodontia services in the Basic Plan

Basic Plus Plan

- Plan Year Deductibles—individual $50, Family $150
- Annual Maximum Benefit for an individual—$2000
- Preventive and Diagnostic Services, e.g., routine cleanings, oral evaluations, fluoride treatments, full-mouth and bitewing x-rays, sealants
  - No deductible
  - Paid at 100% of PPO in-network pricing
- Basic Services, e.g., composite (white) fillings, amalgam (silver) fillings, extractions, surgical periodontal (gums), root canal therapy
  - Deductible must be met before services paid
  - Paid at 80% of PPO in-network pricing
- Major Services, e.g., crowns, full and partial dentures, bridges, implants
  - Deductible must be met before services paid
  - Paid at 50% of PPO in-network pricing
- Orthodontia Services
  - No deductible
  - Paid at 50% of PPO in-network pricing
  - $2000 lifetime maximum orthodontia benefit

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Optional Life Insurance— Provided by Minnesota Life

- There are no changes to optional life insurance benefits for the upcoming plan year.
- For optional child life insurance, dependent children may be covered up to age 26 (coverage terminates the end of the month turning 26).
- Premiums for Optional Child Life will increase slightly.
  - For $5000 of coverage, the premium increases from $0.40 per month to $0.50 per month.
  - For $10,000 of coverage, the premium increases from $0.80 per month to $1.00 per month.
- Remember, there are separate premiums for employees and spouses. View the voluntary life premiums on the Life Insurance Web page.
- Evidence of Insurability (EOIs) MUST be completed when an employee or spouse is applying for new coverage or increasing coverage during open enrollment. This process will occur in the online Benefits Administration System (BAS). At the conclusion of your open enrollment choices, you will be offered a button to begin the EOI process. You complete the EOI form and submit it immediately and electronically to Minnesota Life.
- Children with optional child life coverage must be listed—name, age, social security number—and the optional child life insurance must be indicated for the child by clicking the "yes" button next to their names on the screen for optional child life insurance.
- Use open enrollment to confirm or change life insurance beneficiaries.
- Find more information about Optional Life Insurance on the Life Insurance Web page.

Long-Term Disability (LTD) Insurance— Provided by Standard Insurance

- Premiums for LTD coverage will decrease for FY 2011–12, for both the PERA-vested and non-vested levels of coverage. See the "Insurance Premiums" Web page for the new formulas.
- LTD premiums are a factor of your monthly salary, your age, and your vesting status with PERA.
- Evidence of Insurability (EOIs) is completed when an employee is applying for LTD coverage during open enrollment. New this year, the EOI process will take place within the online Benefits Administration System (BAS). At the conclusion of your open enrollment choices, you will be offered a button to begin the EOI process. You complete the EOI form and submit it immediately and electronically to The Standard Insurance Company. This process will result in faster turnaround times for the review of the EOI.
- Find more information about the LTD program on the Disability Insurance page of the Employee Benefits Web site.

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Flexible Spending Accounts (FSAs)—Administered by ASIFlex

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars to pay for out-of-pocket medical or dependent day care expenses. These contributions lower your taxes. How? The pre-tax deductions lower your taxable income, meaning there is less pay in your check to be taxed. You can then use this pre-tax money to pay for eligible healthcare and dependent care expenses, saving up to 40% on each dollar contributed to an FSA.

- Flexible Spending Accounts (FSAs) do not roll over to the next plan year, so ***those who want an FSA in the next plan MUST enroll in the FSA during Open Enrollment***.
- Two types of FSAs: Healthcare FSA and Dependent Care FSA
  - **Healthcare FSAs**—Eligible expenses include eye exams, dental exams, prescription drugs, routine doctor visits and more—view a comprehensive list at the site of the State's FSA administrator, ASIFlex.
    - Healthcare FSA Maximum ANNUAL contribution: **$6,000**
  - **Dependent Care FSAs**—To qualify for reimbursement, dependent care must be for the purpose of allowing you, and your spouse, if married, to work, and must be for day care for a child under age 13, or for adult dependent care.
    - Remember, Dependent Care FSA ***does not*** cover *medical* expenses for dependents. It can ONLY be used for reimbursement of eligible child care (children under 13) and elder care expenses that allow you and your spouse to work.
    - Dependent Care FSA Maximum ANNUAL contribution: **$5,000**
- The State's FSAs work via reimbursement. You contribute money each month, and then after you incur your expenses, you submit a claim. You are then reimbursed the eligible claim amount.
- Use ASIFlex's tax savings calculator to estimate your healthcare/dependent day care expenses and what you may be able to save on your taxes.
- Those interested in an FSA should understand that it can impact highest average salary (HAS) calculations for retirement purposes. Those close to retirement should contact PERA or a financial or tax professional.

Questions or Problems?

- **Technical questions** about the online system, such as warnings from your computer or difficulties connecting to the site? Call **1.888.460.9627**
- **Questions about the medical and dental plans** (covered procedures, prescriptions, doctors, etc.)? Contact the carriers or plan administrator directly.
  - United Healthcare—1.877.283.5424/welcometouhc.com/colorado (a pre-member site) or myuhc.com (a member site requiring a username and password)
  - Kaiser Permanente—303.338.3800 (Denver/Boulder)/1.888.681.7878 (Southern Colorado)/ kaiserpermanente.org
  - Delta Dental—1.800.489.7168/deltadental.com
- **Problems with username/password in the Benefits Administration System (BAS)** –Try going through the password recovery process by clicking on "Forgot your password" on the BAS login page. If you still have problems, contact your human resources office. Go to the Benefits Web site and click on "Your department's HR/benefits personnel" for a complete departmental list.
- **Questions about eligibility or Internet access?** Contact your human resources office. Go to the Benefits Web site and click on "Your department's HR/benefits personnel" for a complete departmental list.

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Documentation, Documentation, Documentation

You've probably heard a lot about documentation recently. With open enrollment, the dependent eligibility verification process, and the medical insurance supplement program all occurring at or around the same time this year, it is possible you may be asked for some sort of documentation for your spouse or children more than once.

So which processes require documentation? Why might some documentation be required more than once?

Dependent Eligibility Verification Process

for all employees with dependents covered on State benefits

The State has contracted with the firm HMS Employer Solutions to conduct the dependent eligibility verification process. This is a separate process from open enrollment, conducted by an outside third-party, that will help the State to control rising healthcare costs for its employees.

All employees with dependents (spouse/same-gender domestic partner/children) covered on the State's medical, dental, or life insurance plans must provide documentation to verify their eligibility for those benefits. During the month of April, you will receive correspondence from HMS requesting documentation. This letter will describe the type of documentation required, the methods for submitting the documents, and the deadline for submission. **Failure to provide the requested documentation by the deadline will result in the termination of your dependents' medical, dental, or life insurance.**

Open Enrollment

for employees who add covered dependents during open enrollment

Employees who add dependents to their medical, dental, or life insurance during open enrollment must provide documentation to verify the eligibility of those dependents.

Employees will be contacted after the close of open enrollment and asked to provide the necessary documentation (for spouses/same-gender domestic partners: marriage certificates, 2010 tax return, affidavits for common law marriage or same-gender domestic partnership; for children: birth/adoption certificates, appropriate custody documents or allocation of parental responsibility). **Failure to provide the requested documentation by the deadline will result in the termination of your dependents' medical, dental, or life insurance for the FY 2011–12 plan year.**

Medical Insurance Supplement Program

for employees applying for the supplement program

The supplement is for low-income employees with dependent children who will enroll in one of the State's medical insurance options during open enrollment, or be willing to enroll if approved. The supplement is used to cover a portion of the cost of medical insurance premiums for the FY 2011–12 Plan Year (July 1, 2011–June 30, 2012) for approved applicants.

As the program is need-based, applicants must provide documents to verify household income (2010 tax documents for all filers in the household), documents for their spouses/same-gender domestic partners (marriage certificates, affidavits for common law marriage or same-gender domestic partnership) and documents for children in the household (birth/adoption certificates, appropriate custody documents or allocation of parental responsibility). **Failure to provide the requested documentation as part of the application will result in an incomplete application, which will not be reviewed.**

New Application Period for **Medical Insurance Supplement**

Apply April 20–May 23

The supplement for medical insurance will again be available to qualified low-income state employees with dependent children. **This year the application period coincides with benefits open enrollment, Wednesday, April 20–Monday, May 23, 2011.** By placing the application period during open enrollment, approved applicants will receive their supplement for medical insurance premiums sooner than in past years.

Possible applicants should be aware that as part of the online application, the required documentation (such as 2010 federal tax forms, marriage certificates, and birth certificates) **must be in electronic versions, PDFs or JPGs, to be uploaded as part of the application process**. Applications without the electronically attached documents will be considered incomplete and will not be reviewed.

What is the Supplement Program and who is it for?

The supplement is for low-income employees with dependent children who will enroll in one of the State's medical insurance options during open enrollment, or be willing to enroll if approved. Employees who do not choose a State medical plan during open enrollment, but who are approved for the supplement, will be given an opportunity to enroll in one of the state medical insurance options at a later time.

The supplement is used to cover a portion of the cost of medical insurance premiums for the FY 2011–12 Plan Year (July 1, 2011–June 30, 2012) for approved applicants.

More Information

Employees interested in applying for the supplement program are encouraged to review the Medical Insurance Supplement Program Web pages. There they can find information on how to apply and minimum qualifications, along with a Special Edition of HealthLine on the Supplement Program.

Employees with questions or limited computer or Internet access should contact their department's benefits or human resources (HR) offices. Personnel in these offices can answer questions, offer assistance in accessing and completing the online application, and help in uploading documentation into the application. If you don't know how to contact your agency's benefits or HR office, call 303.866.3434/ 1.800.719.3434 to find out.

Division of Human Resources

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